

**Authorization to Use or Disclose My Health Care Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**I. My Authorization**

A. I authorize  PICMC or  (another provider) \_\_\_\_\_ to use or disclose the following health care information (check all that apply):

- All health care information in my medical record **except for items in B below, unless INITIALED**
- Health care information in my medical record relating to the following treatment or condition: \_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g., X rays, bills), specify information and date(s): \_\_\_\_\_

B. I specifically authorize the above named providers to use or disclose health care information regarding testing, diagnosis, and treatment for (**INITIAL** those that apply):

- \_\_\_ HIV (AIDS virus) \_\_\_\_\_ Mental health/ Psychiatric disorders/Depression
- \_\_\_ Sexually transmitted disease \_\_\_\_\_ Drug and/or alcohol use

C. This health care information may be disclosed to:

Name (or title) and organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

D. Reason(s) for this authorization (check one):  at my request  other (specify) \_\_\_\_\_

II. My Request to copy my records: I authorize PICMC to copy and provide me with my health care information for the dates: \_\_\_\_\_

I understand that PICMC will provide me with up to **10 pages** without charge. Requests for records that exceed 10 pages are filled by Secure Health Information Corp. There is a fee for this service.

**This authorization ends:** (*This document does not permit disclosure of health information created after the date it is signed unless my initials are here \_\_\_\_\_*) (check one below)

- in 90 days from the date signed  on (date): \_\_\_\_\_
- when the following event occurs: \_\_\_\_\_  
(no longer than 90 days from date signed)

**III. My Rights**

- ❖ I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:
  - To take part in a research study or
  - To receive health care when the purpose is to create health care information for a third party.
- ❖ I may revoke this authorization in writing. If I do, it will not affect any actions already taken by PICMC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance
- ❖ Two ways to revoke this authorization are:
  - Fill out a revocation form. A form is available from the PICMC reception desk. Or
  - Write a letter to the PICMC Privacy Officer.
- ❖ I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative)